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Medicine and mutilation

Oxford, Manchester
and the impact of the
1832 Anatomy Act



In the late 18th century, the knowledge of anatomy was increasingly accepted as the linchpin of medical training, which therefore relied on a supply of cadavers.

Large numbers of bodies were required by growing ranks of medical students, as there was no satisfactory method of preserving bodies. The Anatomy Act was introduced in 1832 to remove the taint of body-snatching from the profession. It allowed anatomists to request so-called unclaimed bodies from workhouses.

Historiographers of the Anatomy Act remain divided over its impact. Ruth Richardson's path-breaking study elevated its importance in the decline of private medical schools and as a fore-runner of the 1834 Poor Law Amendment Act. But several Poor Law historians contest this focus, and the Anatomy Act has been labelled "a peripheral piece of legislation". Russell Maulitz and Adrian Desmond argue convincingly that the private schools disappeared as a result of the metropolitan hospital bias of the Royal College of Surgeons and not, as Dr Richardson asserts, as a result of the Anatomy Act. Elizabeth Hurren has adjusted the historiography further with her work on Cambridge anatomy in the late 19th century, discovering a thriving anatomy school and concluding that: "We still have scant knowledge of the inner workings of anatomical schools and their acquisition activities." My own work engages with these debates by re-examining the Anatomy Act and the provision of medical education outside of the often traditional focus on London.

Above:

Royal Manchester Infirmary. Coloured lithograph by J Arnout.

Cover:

Burke and Hare suffocating Mrs Docherty for sale to Dr Knox, 1829. William Heath

There came in the early 1800s in England a gradual acceptance of the European model of medical training, with the hospital at the centre of education and research, complemented by a range of lectures and demonstrations at the medical school that correlated

closely with clinical observation. This model had developed out of the rise of morbid anatomy within French medical education, rejecting "an earlier interpretation of diseases as general physiological imbalance" in favour of a "clinical view of a specific disease linked to lesions observable at autopsy". Promoting this approach helped to elevate the role of surgery and dissection over physic, and anatomical training relied on the many cadavers provided by large Paris hospitals with high mortality rates.

Manchester and Oxford provide a contrast between an ambitious new centre with the first fully organised provincial medical school, and a highly traditional centre for medical training. Before the Anatomy Act, the only legal source of bodies for anatomists in England had been the gallows, giving a supply of murderers as a result of the 1752 Murder Act. Oxford University benefited from this, acquiring bodies from Oxford, Reading and Abingdon Assizes, albeit in very limited numbers. There is no evidence of a thriving trade in cadavers (unlike in Manchester). John Bellers believed that there were few bodies available for the Oxford anatomists, given that "the mob are so mutinous to prevent their having one". Yet the recent discovery of a cache of 2000 bones in a pit at Oxford's Ashmolean Museum (the original University anatomy school) provides contradictory evidence from an early period. The collection includes dissections that took place prior to 1767, when the school moved premises. The number of remains found – and the presence of children – suggests that body-snatchers were the suppliers.

The private anatomy schools of Manchester received very few bodies from the gallows and were dependent on resurrectionists for teaching material. A survey of the *Manchester Guardian* of the 1820s demonstrates that this supply was abundant, with surpluses being sent on by stagecoach to Dr Robert Knox in Edinburgh (the anatomist supplied by Burke and Hare) and to London medical schools.

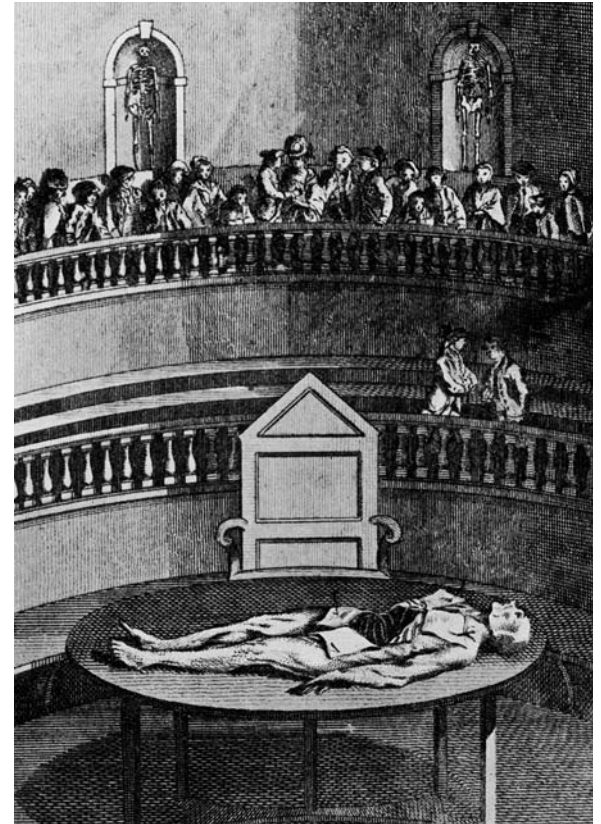
Following the Anatomy Act, anatomists could claim bodies from workhouses and other public institutions, including voluntary hospitals. Regrettably, the records for the Oxford and Manchester anatomy schools rarely refer to sources of supply, and the Poor Law records are scant, so my research has focused on the minutes of the relevant voluntary hospitals, the national Anatomy Inspectorate and personal papers and newspapers.

After the Act, special arrangements were made for Oxford to receive bodies from the floating prison hulks (as Cambridge did). Anatomy Inspectorate figures show that Oxford had a very poor supply from these and did not develop an alternative. Oxford's Radcliffe Infirmary rarely granted unclaimed bodies to the anatomy school at the University, going to great lengths to locate relatives or parishes willing to undertake burial. In 1839 the Governing Board (composed of lay members) ruled that no dissections were permitted, saying that while it was "favourable to scientific enquiries of this sort it forbids the dissection of any Patient in the Infirmary for the sake of mere anatomical demonstration". There are no surviving records from the Oxford workhouse for the 19th century, but in 1861 the Professor of Anatomy wrote to the neighbouring Poor Law Union in Headington. The Guardians of the Union resolved unanimously that no bodies would be sent to the school.

Elizabeth Hurren has outlined the costly determination of Cambridge anatomists to procure a supply of bodies. The Oxford Professor of Medicine Henry Acland recognised that Oxford did not have the necessary dedication: "A practical school of medicine might be founded in Oxford; but the difficulties would be great and the cost enormous." At the end of the 19th century, Professor of Physiology John Scott Burdon-Sanderson agreed with the commitment made by Cambridge University: "Cambridge has had the advantage of a great scientific surgical teacher who possessed or made opportunities we have not." Acland and his colleagues attempted to develop Oxford's role in general scientific education over medical specialisation. The geographical position of the University meant that practical training was available at other centres and Acland recognised that the cost of developing a clinical school was difficult to justify: "If Oxford attempts to rival the great metropolitan schools, or the Victoria University [the University of Manchester], it will fail."

As many of the Poor Law records for Manchester have been destroyed, much of my research has focused on the Anatomy Inspectorate, the archives of the Manchester Royal Infirmary and the limited records of several competing private anatomy schools. It seems that Manchester experienced a problem in maintaining a regular supply, and acted in accordance with the Anatomy Inspector's conviction of 1832: "The existence of two or more schools in some of the smaller towns where the supply of dead bodies is limited is an evil so self evident that I have endeavoured to impress the advantages of a coalition on the minds of the teachers and I hope successfully in more than one instance." The two major anatomy schools of Manchester united

to become the Royal School in 1836, and further amalgamations took place in the 1850s. Despite this, the Anatomy Inspector often expressed his frustration over the poor supply from Manchester workhouses, gaols and the county lunatic asylum.



Much of my research supports Ruth Richardson's contention that the Anatomy Act was a fatal blow to the private anatomy schools of London and the provinces, but the new bylaws of the Royal College of Surgeons were certainly a factor that requires investigation. In 1822 the College refused to recognise dissection taking place in the summer, arguing the practice was a health hazard to students and the wider public. This was a direct attack on the private schools, where anatomy was taught throughout the year to reduce costs. The College also demanded longer periods of 'ward-walking' in the provincial hospitals than those required in London; Manchester Royal Infirmary complained vociferously about this throughout the 1830s, requesting the same status as the hospitals in London, Dublin, Edinburgh, Glasgow and Aberdeen. It seems that the private medical school in Manchester may have suffered from periodic shortages of cadavers, but many of its struggles were with the Royal College of Surgeons.

Oxford University, on the other hand, found it difficult to respond to the transformation of medicine and became a limited, provincial medical school for physicians who would have to complete the practical side of their training elsewhere. Oxford's lack of success in procuring cadavers was a major reason for this failure to adapt.

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Above: Interior of the Theatre at Surgeons Hall showing the body of a murderer exposed on the table, c.1745–1800.

Missionary leprosy work in colonial Taiwan

WEN-JI WANG

In the first half of the 20th century, when colonial governments were generally reluctant to launch comprehensive anti-leprosy programmes, international charity organisations and medical missionary workers were keen on tackling this highly stigmatised disease.

Such a situation developed in colonial Taiwan (then Formosa). Following the work of Sanjiv Kakar, Michael Worboys and others, this project looks into the work of charity and religious organisations through a historical account of the career of Dr George Gushue-Taylor (1883–1954).

The specificity of the Happy Mount under Gushue-Taylor's direction can only be understood by expanding the scope of analysis.

With the assistance of the London-based 'Mission to Lepers' and the Japanese colonial Government, Gushue-Taylor, a Canadian medical missionary affiliated with the Presbyterian Church, established a special skin clinic and a leprosy institution in northern Formosa in the late 1920s and early 1930s. The case of Mackay Memorial Hospital's leprosy dispensary and Happy Mount Leprosy Colony is enlightening in that different systems of public health were at stake and that the interests of a local medical missionary were often in conflict with those of an international organisation and the colonial Government. Gushue-Taylor's original plan of building a small leprosarium was repeatedly rejected by the Mission to Lepers on the grounds that such responsibility would go far beyond the capabilities of the institution and local missionaries. In contrast, for Gushue-Taylor and a number of contemporary leprologists, outpatient dispensaries would very likely become centres for the spread of the disease. As the cure consisted largely in the improvement of the individual's bodily resistance and general standard of living, a leprosarium or a leprosy colony was seen as the answer.

Happy Mount Leprosy Colony opened in 1934, with 20 cottages in total, each catering for four patients. They were constantly engaged in communal work, such as road and house construction and repair, bush clearing, vegetable growing and animal farming. 'Leper colonies' or 'settlements', which were common in British Africa and India at the time, were founded with a stress upon agricultural and industrial work and physical exercise. In Happy Mount, Formosan patients sampled Christianity embodied in modern Western civilisation,

self-government, and, as a Canadian pastor put it, "the colony spirit". The formation of citizenship that Megan Vaughan and Warwick Anderson have analysed in the cases of British Africa and the American Philippines can also be seen in the present study. However, as Formosa was then a Japanese dependency, Happy Mount as 'a colony within a colony' requires further analysis.

What Gushue-Taylor envisaged was more than an agricultural colony promoting self-reliance and self-rehabilitation. Happy Mount and Mackay Memorial Hospital were designed as part of a public health network. After training, suitable patients at Happy Mount were put in charge of uncomplicated medical care, just as their counterparts in colonial India and Africa were. Young and intelligent ones were taught the principles of personal and public hygiene. In addition, propaganda



and educational programmes were undertaken to instruct both the public and the medical profession about the nature of the disease. Medical workers from the Hospital gave treatment to leprosy patients at the local beggars' home on a regular basis. Furthermore, Gushue-Taylor and his associates provided expert knowledge and medications to several local physicians who were willing to join their work.

For Gushue-Taylor, and perhaps gradually for some of his patients, Happy Mount Leprosy Colony became more than a 'model village' of modern civilisation. Work therapy and its complementary measures were employed as a model to criticise the Japanese health policies. The aim of Happy Mount was to help people with leprosy return to society after their symptoms disappeared. In contrast, all the anti-leprosy programmes put forward by the Japanese Government and its leprosaria were more concerned about passive prevention and compulsory segregation. It is no surprise to find Gushue-Taylor highly critical of the Government's statistical and logistical mindset.

Above:

Formosan nurses, Mrs Gushue-Taylor injecting. Outpatient leper dispensary, Taihoku, Formosa (1927)

Leprosy Mission International Archives, Brentford, Middlesex, UK

Warwick Anderson and others suggest that it is imperative to rewrite previous nation-centred histories of science and medicine. One should instead look into the way in which bodies of knowledge, products and technologies travel. The specificity of the Happy Mount under Gushue-Taylor's direction can only be understood by expanding the scope of analysis. His work was that of transmission, translating the British colonial experience to a Japanese dependency. Yet Happy Mount was not

an exact replica of the Indian or African system. Its distinctiveness was refashioned constantly by mediation between the international charity organisation, the colonial Government, the local and mother churches, the patients, medical missionaries, and the disease and its changing conceptualisations and treatments.

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Cooperative medical services in rural China, 1949–83

FANG XIAOPING

Rural health has been a problem for developing countries across the world, including China. During the three decades after 1949, the Chinese Government implemented a series of policies to improve rural health. Among these, the most remarkable were Barefoot Doctors and Cooperative Medical Services (CMSs) from the late 1960s to the early 1980s.

Barefoot Doctors were health workers, with primary and middle school education, in production brigades of the People's Communes. They received basic medical training for a short time and were mainly responsible for epidemic prevention and vaccination, patriotic health campaigns, and offering simple treatment to Commune members.

A CMS was a kind of medical fund system. Usually, production brigades set up CMS stations, which were presided over by Barefoot Doctors. A fund consisted of the brigade's accumulation fund, plus annual fees paid by the Commune members. A member who sought health services at a CMS station could be exempted from parts of the medical expenses.

The services were believed to play an important role in improving rural health after 1949, but given the collapse of the People's Communes in the early 1980s, Barefoot Doctors and CMSs declined gradually. The rural health situation since the early 1980s, and deficiencies exposed by the severe acute respiratory syndrome (SARS) incident in 2003, have prompted

some to reconsider this shift. However, Barefoot Doctors and CMSs were not purely healthcare phenomena: because of the complex political era from the late 1960s to the early 1980s, the services also reflected other factors, such as changes to rural society and the population's reaction to state power.

Barefoot Doctors and CMSs were not purely healthcare phenomena

My doctoral dissertation aims to study Barefoot Doctors and CMSs by focusing on the practical operation of the services, and the reaction, acceptance and participation of peasants in rural society, against the wider background of the interactions between the State and rural doctors in the different eras of the 20th century. I selected four former Communes in three counties of Hangzhou Prefecture in the eastern Zhejiang Province as case studies, based on their economic development and geographic features.

The first fieldwork was done from November 2003 to June 2004 in Zhejiang, Hubei, Shanghai, Jiangsu and Hong Kong. I have surveyed materials such as the archives from Provincial, Prefecture and County Archives, and various gazettes, newspapers, magazines, and Barefoot Doctor textbooks. A wealth of useful information came from interviews with around 30 former Barefoot Doctors, and 20 peasants and ex-officials of health departments, including the initiator of the CMSs and the first woman Barefoot Doctor.

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Indigenous medicine and popular culture in colonial north India, 1900–1950

RACHEL BERGER

The historiography of medicine in colonial India has dealt primarily with the imposition of an imperial medical system upon the subcontinent.



Much research has concentrated on the permeation of Western medicine by imperial ideologies, which resulted in a colonial ordering of health and the 'tropical' body. This approach has failed to provide us with a model for studying the systems that did not derive their legitimacy primarily from the colonial State. This neglects the experience of the majority of the Indian population in the early 20th century, for whom access to healthcare services was primarily unregulated and local.

My research analyses Ayurvedic healthcare practices in north India, focusing on urban centres in the United Provinces in the late colonial period. While informal healthcare practices, particularly in rural areas, pose difficult methodological problems owing to a lack of sources, there is ample vernacular literature associated with the more regularised healthcare network of India's expanding urban centres. These sources illuminate the social networks and the consumption patterns of the emerging middle class, a key constituency of the north Indian nationalist movement. Studying the practice of Ayurveda in the United Provinces illuminates not just the social life of medicine in a colonial setting, but also the class formation 'project' of the Hindu bourgeoisie.

Recent research has dismantled the colonial model of indigenous medicine, uncovering and addressing Ayurvedic and Unani medical texts. However, my research emphasises the importance of networks that connected abstract theorising to living medical practice. For individual consumers, access to healthcare services

constituted a key lifestyle aspiration that many increasingly considered could be better fulfilled within an independent India. Indigenous medicine was of particular relevance to this discussion as it provided an 'authentically' Indian tradition from which an alternative, non-colonial, legitimacy could be derived. This was balanced by simultaneous pressure within the nationalist movement to construct modernity through the modification of colonial approaches to knowledge. This was at some level a debate about whether Ayurveda should be understood as a static, fixed body of knowledge or as an evolving one in dialogue with Western and other healthcare systems. I argue that this debate should be understood as a politically pressing argument about the nature of cultural authority in an independent India.

I am examining the Hindi-language press, both popular and technical, in order to consider discussions of medicine within the emerging Hindi public sphere. The importance of this public sphere to the nationalist movement has become a commonplace of recent historiography. I argue that the importance of medical writing in the formation of this modern literary tradition has been underestimated. Medical writing was understood to be critical in securing the health of physical bodies, out of which the emerging Indian nation was to be created. Furthermore, for most authors, the vitality of indigenous healthcare systems represented the capacity of Indian knowledge and Indian understandings of science and nature to govern effectively a new independent state.

My research considers the incorporation of gender and sexuality into discussions of Ayurveda, a neglected field that, I argue, was crucial to the relationship between nationalism and indigenous medicine. During the 20th century, it became possible for authors who had not been trained in Sanskrit, including women, to write authoritatively on Ayurveda. The increasing participation of women in the medical public sphere was paralleled by the growing importance of the domestic sphere in popular culture. Moreover, the knowledge articulated by female authors was lauded for its simplicity and its authenticity, generating an alternative meaning of indigeneity that referred to the 'unsoiled' practices of the 'home', which had been closed off from the intrusion of the 'world'. This resulted in a complex discussion of the body and its desires, which drew upon gendered norms and conceptions of appropriate sexuality, even while the nationalist movement gave a new urgency to those norms as a political imperative.

My work also suggests that Ayurveda became increasingly important to both nationalist social policy and public health in the 1940s. In particular, Ayurvedic writing on reproduction and reproductive health became increasingly influential alongside rising awareness of a potential

Above:
An Ayurvedic
medical practitioner
at work.

‘population explosion’. To prevent India’s overpopulation with ‘unfit’ bodies, campaigners increasingly debated healthy fertility. From the 1920s on, Ayurvedic guides and less formalised writing about ‘indigenous’ medicine included long sections on the female reproductive body, focusing in particular on the conception of strong, healthy babies, going substantially beyond the canonical texts of Ayurveda. Not only was popular medical literature reflecting the wider population

control agenda, but also the State was increasingly using Ayurveda as a tool for reaching the public in order to curb potential health crises. My work suggests that an examination of Ayurveda is crucial to understanding the medical practice and scientific discourse of India in the nationalist period.

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‘John the physician’: Rediscovering a Byzantine medical text

BARBARA ZIPSER

Byzantine medical texts have for a long time been neglected by researchers and remain mostly unedited, although in terms of quantity many more such works have come down to us than from the Classical Period.

Some of the reasons for this rather asymmetrical situation are purely practical: most of the Byzantine medical manuals are very long, have been written in a rural dialect and have undergone redactions that render the editing more complicated and time-consuming, and almost impossible without the help of computers.

But also the low esteem of this late, dialectal and sometimes disorganised material has contributed to the fact that very little of it has been made accessible in printed form. Byzantine texts were often regarded as inferior to their predecessors and only of use as a quarry where one could find otherwise lost Classical fragments. And, in fact, most of them are not concerned with scholarly medical theories, but rather show how the sophisticated concepts of earlier times were adapted to the needs and limited resources of the contemporary medical practice. Despite the immense historical value of these data, they were not of philological interest.

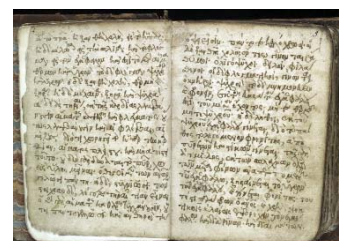
Thus, the treatise *On therapeutics* (usually attributed to a mysterious ‘John the physician’), which had been listed by Fabricius 200 years ago among important works that needed editing, until now has never been subject to any detailed research. The structure of the work is rather confusing and differs in all of the manuscripts. Even if the modern reader bears in mind that practical manuals have often been modified by scribes, some details are very surprising. It consists of several parts, the most prominent being a vast compilation of chapters that are partly organised in the conventional order from head to toe, but sometimes seem to be in random sequence. These chapters have clearly been compiled from very different sources, such as commentaries, classical compendia or vernacular

recipe books. As was common practice, a table of contents was added, listing all the chapter headings.

Usually, a treatise starts with a title, which might be followed by an introduction, a table of contents and finally the actual text. Most of the manuscripts have all of these elements, but not in the order one would expect. Some have several titles in various places. Also, most of the introduction does not refer to the rest of the text. Was at least one of the titles not that of the treatise by John the physician but written on the codex cover to refer to the person who brought together several medical texts – and therefore not the introduction to the compilation but an independent text?

The reader is left wondering about what the original autograph might have looked like. Maybe once there was a seminal text, which was augmented later on and became popular in the form it has now. That it was a very influential and widely used book is certain, for it has been copied many times and was extensively redacted. Certainly, it was made for practical use. Most of the manuscripts that have come down to us originate from scholarly libraries, but most of the books actually used by practitioners are lost. In the case of John’s manual, one tiny and badly torn codex, now held in the Wellcome Library (MSL 14), has survived. Apparently written in the late 14th century by a bilingual scribe, it was later used by several people who amended the text and added other marginalia to assist in their practice.

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Right:

On therapeutics by John the physician.

Healthy environments?

CATHERINE J MILLS

Interest in the relationship between health and the environment has until recently largely been displaced by a preoccupation with lifestyle and genetic or inherited explanations of disease.

A renewed interest in the significance of 'place and space', and a developing awareness of the ecological dimensions in relation to health, initially re-emerged among environmental historians in North America such as Christopher Sellers and Gregg Mitman. British scholars, including John Hassan and Stephen Mosley, are similarly returning to the exploration of environmental themes within the context of medical history.

The University of Exeter's Centre for Medical History is committed to integrating environmental and medical histories in the modern period, thereby providing an opportunity to continue to develop and expand this combined field of study. Recent projects have focused upon histories of environmental and occupational respiratory diseases. Closely related to this research is the exploration of the relationship between atmospheric pollution, respiratory disease and the regulatory politics of clean air in postwar Britain.

Urban smoke and respiratory disease have long been associated in Britain. Legislative controls in place in the immediate postwar period were a legacy of medical and economic anxieties that first emerged in the 17th century and flourished in the mid-19th and early 20th centuries. This stimulated strong local activism, particularly in London and large provincial industrial centres, but resulted in piecemeal interventions that were largely ineffective.

Calls for national policy initiatives began to surface from the early 1950s, and the 1956 Clean Air Act marked the first significant step in the national pursuit of a healthy atmosphere. This combination of environmental and health concerns in an innovative legal framework poses interesting questions for historical study. Was enactment of the law a political response to the persistent and impenetrable mix of smoke and fog that claimed the lives of roughly 4000 Londoners in December 1952? Did national policy build upon earlier environmental explanations of disease? How far did the health debate represent contemporary thinking in early 'social medicine'? And to what extent was intervention a precursor to the fundamental tenets of what would become the new public health?

The current literature on the modern history of air pollution and health is sparse and provides a broad survey only of the background to the 1956 reforms,

largely from political and national perspectives, and suggesting a tardy response by the British Government to the London smog (see R Parker's 'The Struggle for Clean Air' and E Ashby and M Anderson's *The Politics of Clean Air*). An ongoing project at the Centre for Medical History proposes a deeper and more sophisticated analysis, grounded in epidemiological evaluations of human risk and contemporary trends in public health, and exploring environmental and medical interests within the context of competing political, socioeconomic, technological and cultural tensions out of which national policy initiatives emerged.

To facilitate an extensive and composite survey of reform, the research will focus on three key subject areas representing the wide arena within which the politics of clean air operated: 'Fuel Efficiency and the Economy'; 'Smoke Abatement, Regulation and Control' and 'Housing and the Domestic Hearth'. The period of study, from 1945 to 1975, encompasses critical moments both in the history of smoke abatement and in the provision of public health. Particular emphasis is placed upon domestic smoke abatement, which constituted the main thrust of the 1956 legislation. The singular critical theme unifying the diverse strands of the project is the shifting preoccupation with respiratory disease and atmospheric pollution, demonstrated by key participants active in either the promotion or obstruction of reform.

The project has revealed rich and accessible source material at both local and national levels. Early analysis suggests that cleansing the air was a minority interest, largely promoted by an informed and often female middle class in advance of viable technological solutions, and was distanced from both the 'man on the street' and the working-class home. Although rising incidence of respiratory disease was a persistent and underlying concern, the relationship with air pollution was complex and often appeared ambiguous: there was no established medical interest group; exposure to air pollution predisposed towards many diseases; and the medical evidence was equivocal. With the exception of the London smog, medical and environmental anxieties were largely obscured by other dominant concerns in the wider postwar political and socioeconomic arena. 'Clean air' was promoted to serve a variety of objectives, ranging from fuel efficiency to notions of civic pride, issues often far removed from the respiratory health of the nation. Despite a novel mix of medical and environmental strategies, the 1956 Act was simply a pragmatic response by the Government to a peculiar set of circumstances that followed in the aftermath of war. The aim of this project is to unlock and explore those circumstances and complexities.

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Altitude medicine and physiology

JORGE LOSSIO

During the late 19th century, altitude physiology emerged as a scientific discipline devoted to revealing the mechanisms of adaptation to low-oxygen environments. It was believed that studying the mechanisms of response to these environments could help solve pathological problems found at sea level, particularly those related to the oxygen transport system.

High-altitude areas were regarded as a huge natural laboratory for the study of hypoxia and respiratory-related problems. Scientists visiting these regions were particularly surprised that millions of people lived, worked and reproduced ‘normally’ at heights that surpassed the summits of the Swiss Alps. They were also shocked by the physical capabilities of native residents and that sports such as football were popular, despite the diminished amount of oxygen in the environment. In my doctoral research, I explore how physiologists transformed medical and lay attitudes towards altitude regions and ‘altitude populations’ between 1890 and 1960.

This project’s scope ranges from the emergence of a group of physiologists interested in the effects of altitude exposure to the consolidation of a network of altitude physiologists with broader concerns about life at high altitudes. The aims of this project are: to uncover the contexts of application that encouraged scientific research in altitude acclimatisation; to explore the medical construction of a ‘high-altitude man’; and to explore the construction of a ‘high-altitude pathology’, understood as the combination of diseases produced by altitude exposure and the effects a hypoxic environment engendered in the evolution and incidence of diseases in general. Although I will focus my research in the Peruvian Andes, I hope that by considering the interactions between British, American and Latin American scientists, I will add a global dimension to the existing literature on the subject.

The notion of ‘high-altitude man’ as a distinct biological entity emerged as a reaction of local scientists to the images produced by Western physiologists on the inferiority of altitude residents. To the thesis proposed by the Cambridge physiologist Joseph Barcroft that full acclimatisation to high altitudes was impossible and that “all dwellers at high altitudes are persons of impaired mental and physical capabilities”, the Peruvian clinician Carlos Monge responded by stating that “altitude people” were “the race with the greatest physical performance of the world”. He argued that high-altitude people possessed a distinct biology, with unique physical, chemical and functional peculiarities that rendered

them more capable of surpassing the effects of hypoxia. I intend to see how physiological research led to a deeper alienation of altitude residents and transformed the attitudes of national social elites, policy makers and public health authorities towards life at high altitudes.

Experimentation on the physiological effects of altitude exposure on the human body advanced in parallel with the study of its pathological effects. Doctors believed that the anatomical, chemical and functional modifications produced by exposure also had implications for disease incidence and evolution. Thus, altitude physiologists began to explore the effects of altitude exposure from a clinical standpoint. Altitude acclimatisation debates are particularly interesting, because life at high altitudes was depicted as in a delicate physiological equilibrium, at the boundaries of the normal and the pathological. Physiologists had many difficulties regarding what to consider pathological and what to consider normal at high altitudes; however, they tended to define ‘normal’ as the functions the human body could perform in the lowlands.



Finally, I intend to explore the varied contexts of application that encouraged altitude acclimatisation research. During the late 19th century, altitude acclimatisation was studied in order to explore the feasibility of ‘white people’ acclimatising to, and thus colonising, tropical highlands. Respiratory physiologists believed that studying the bodily mechanisms of response to low-oxygen environments could help to solve pathological problems found at sea level, particularly those related to the oxygen transport system. Another important context of application was the military. Both the US Air Force and the Royal Air Force became particularly interested in several aspects of altitude acclimatisation after World War I.

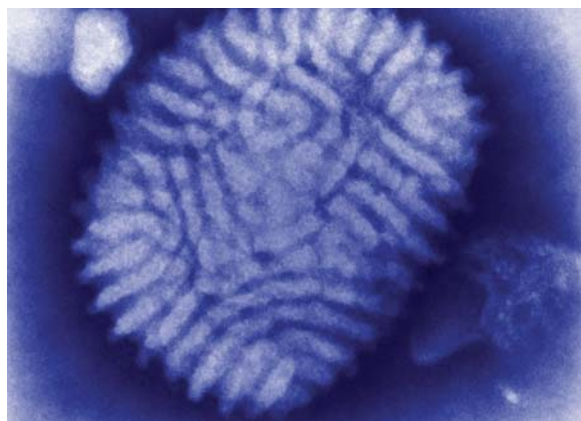
Jorge Lossio is a doctoral student at the Wellcome Unit for the History of Medicine, University of Manchester, UK.

Above:
Experiments in
altitude physiology.
Alberto Hurtado
Papers, UPCH
Thanks to Dr Roger
Guerra García for
providing this picture.

Myxomatosis in Britain, 1953–1970s

PETER BARTRIP

Rabbits are not native to the British Isles. The manner and timing of their arrival has long been debated but they have certainly been present for over 900 years – perhaps much longer.



They appear to have caused little concern as pests until the 18th century, when changing agricultural and field sport practices created conditions in which they flourished. By the 1840s, voices were calling for their elimination. From the 1880 Ground Game Act to the 1947 Agriculture Act, numerous measures were introduced to control the “destructive little animal”. In its millions the rabbit was trapped, gassed, snared, shot, netted, ferreted and poisoned. To little avail: by the 1950s its numbers may have reached 100 million. The Ministry of Agriculture and Fisheries (MAF), along with the Forestry Commission, the National Farmers’ Union and others, continued to ponder a solution. Even animal protection organisations agreed that vigorous measures were needed. Before long, myxomatosis supplied the ultimate biological weapon of mass destruction.

Myxomatosis is a viral disease that almost exclusively affects the European wild rabbit and its domesticated relatives. Principally spread by insect vectors, it has symptoms including swelling and mucous discharge; the fatality rate can be extremely high. The disease was first observed among laboratory rabbits in Montevideo in 1896. By 1919, it had been identified as a potential solution to the rabbit problem in countries where the animal was a serious pest. After experiments and trials in Britain and Australia, it became established, to devastating effect, in Australia in 1950–51. In 1952, it was deliberately introduced to France by a retired physician who occupied a rabbit-infested estate near Paris. In autumn 1953, it arrived in Britain, initially near the town of Edenbridge in Kent. MAF officials at first tried to contain it. Once this proved impossible,

it was allowed to run its course; rabbits were soon dying *en masse*. As the disease spread, the Government tried to grasp the opportunity to clear the country of rabbits. Extermination was not, of course, achieved, but with myxomatosis remaining enzootic, the British rabbit population is probably 50 per cent or more below pre-myxomatosis days.

Although the history of myxomatosis as an Australian or global phenomenon has received considerable attention, Britain’s experience has been much less researched. Questions abound. How did the disease reach the UK? No previous study has alleged government involvement, but circumstantial evidence suggests that myxomatosis might have been introduced with official blessing. How did the disease spread within the country? The rabbit flea was the key vector but, at least until the 1954 Pests Act criminalised intentional transmission, some farmers spread the disease deliberately.

The mass destruction of a mammal by a virus evoked a range of responses. At first, prefiguring later animal disease crises such as BSE and avian influenza, some feared that myxomatosis might jump the species barrier and affect humans. In contrast, many farmers and foresters welcomed the disease for self-interested economic reasons. The general public, reared on cultural traditions that portrayed the rabbit sympathetically, often expressed outrage at heaps of dead, decomposing and fly-blown rabbits, especially in light of recent outbreaks of poliomyelitis. Less predictably, some animal welfare organisations were little troubled by the disease; they preferred it to the gin trap, a device they had long wanted banned. The environmental impact of myxomatosis was much debated: some forecast the spread of scrub and drastic consequences for predators deprived of a staple prey; others anticipated recovery of vegetation and a decline in soil erosion. Beyond such debates, it is arguable that in the pre-*Silent Spring* era, myxomatosis helped foster concern about the future of the natural environment.

Dr Peter Bartrip is Reader in History at University College Northampton and Research Associate at the Centre for Socio-Legal Studies, University of Oxford (E peter.bartrip@socio-legal-studies.oxford.ac.uk).

Above right:
Etching of rabbits
by J Tookey
(after J C Ibbetson).

Above left:
The Myxoma virus,
responsible for
myxomatosis.
David Gregory and
Debbie Marshall

Homeopathy in historical context

LYN BRIERLEY-JONES

This workshop, held on 22 September 2004 at the Wellcome Trust Centre for the History of Medicine at University College London, sought to elucidate the impact homeopathy has had around the world.

Phil Nicholls of Staffordshire University highlighted the schism that occurred in interpretation and organisation within British homeopathy from the outset. Frederick Quinn spawned an elite, formally educated and professionalised group of homeopathic practitioners forming the British Homeopathic Society, providing medical services for the rich and aristocratic (its alliance with the royal family continues to this day). Simultaneously, John Epps formed the English Homeopathic Association, based upon his democratic values and encouraging lay and domestic healing, particularly attracting middle-class mothers.

Nadav Davidovitch from Ben-Gurion University, Israel, looked at the Hahnemann monument in Washington, DC as a symbol of homeopathic identity. Whereas in the mid-19th century, American homeopaths had constructed Samuel Hahnemann as a “persecuted medical rebel”, by the end of that century Hahnemann was envisioned as a “researcher, experimenter and scientist”, this latter conception being enshrined in the monument. Davidovitch concluded, therefore, that especially in its dialogue with allopathy, homeopathic identity was and is undergoing continual reconstruction.

The second session took delegates farther afield, to India and Australia. Dhrub Kumar Singh, from Jawaharlal Nehru University, India, described how Mahendra Lal Sarkar, an allopath, turned to homeopathy in 1860s

Bengal in the face of the cholera epidemics. Sarkar’s success as a homeopathic physician led him to construct not a homeopathic medical college, however, but an Institution of Science, where his vision of the plurality of therapeutic science could be celebrated. Today, a bust of Sarkar stands in the Institute. While Sarkar’s image rests on a copy of Hahnemann’s *Chronic Diseases*, his homeopathic identity has been lost to history – almost.

Francis Treuherz reported on the use of homeopathy in 19th-century Aboriginal Australia. Rosendo Salvado, a Benedictine priest from Spain, set up a monastery, agricultural community and schools in New Norcia, Western Australia. There he treated the native Aboriginal population with homeopathy, particularly for measles and whooping cough. The New Norcia Museum today houses homeopathic books, medicine chests and domestic kits left by Salvado and his associates. It would appear then that, in the 19th century, few, if any, parts of the world remained untouched by homeopathy.

Robert Jutte, from the Robert Bosch Foundation in Stuttgart, described Hahnemann’s style of doctor–patient relationship. Hahnemann’s casebooks show him to have been ‘modern’ in that, in order to preserve the physician’s professional dignity, patients (save the gravely ill) had to visit him. He required cash payment in advance for his services and demanded high patient motivation. The literate were expected to read his *Organon* for information. Many patients appeared happy with Hahnemann’s treatment and stayed with him for years. Several corresponded by letter, with a few criticising his methods. In general, the casebooks reveal Hahnemann as a pragmatist and entrepreneur.

Finally, Lyn Brierley-Jones from the University of Durham described the differential handling of error between American homeopaths and allopaths in the 1870s. Whereas allopaths tolerated epistemological contradiction and therapeutic failure well, homeopaths did not. These differences were explained partly in terms of the rationalism of allopaths and the empiricism of homeopaths, and partly in terms of the differential distribution of power within each group: whereas the American Medical Association encouraged freedom of individual professional judgement, the American Institute of Homeopathy exercised rigid control. Lacking flexibility, homeopaths’ epistemological basis – ‘provings’ – became undermined by a very small number of negative experimental results.

The workshop produced lengthy and fruitful discussions. A wish was expressed to hold an International Conference on Homeopathy at some point in the future. Thanks are due to Hal Cook and the Wellcome Trust Centre for supporting and generously funding this meeting.

Lyn Brierley-Jones is a doctoral student in the Department of Sociology at the University of Durham, UK.



Right:
A patient suffering the effects of homeopathic treatment. Colour lithograph by James Morison, c. 1850.

Frontier medicine

ALEX MCKAY

The term ‘frontier’ can be understood both in relation to political divisions and as signifying zones of encounter between cultures, faiths, ideologies or even individuals.

This idea was explored in regard to medical history at a conference on frontier medicine, held at the Wellcome Trust Centre for the History of Medicine in November 2004.

Alex McKay sought to locate the early 20th-century Indo-Tibetan medical frontier within Frederick Jackson Turner’s (1893) concept of the frontier as a series of overlapping zones. The biomedical frontier became a frontier of modernity, within which European education, science and technology were introduced as a political strategy to gain local support for the colonial project.

Also concerned with the Himalayas was Susan Heydon, who discussed the hospital established by Sir Edmund Hillary in Khunde, Nepal. Heydon located the hospital within different ‘worlds’ – those of Hillary and the Himalayan Trust running the hospital, local Sherpa patients, international aid and the biomedical world – concluding that where those worlds intersect is a frontier to be negotiated.

Mona Schrepf concluded that centre and periphery are only relative locations of power and knowledge in Tibetan medicine. Research among lineage doctors showed that the actual border between proper and cursory training and transmission of medical knowledge and practice runs along traditional lines through master-disciple lineages rather than through state-funded central medical institutions.

Suggesting frontiers of modernity and tradition, Peter Flügel discussed two ‘science of living’ programmes developed within modern Jainism. These supplement classical Jain practices with innovative schemes promoting physical and mental health not only through yoga and meditation, but also through conceptualisation and implementation of blueprints for the ‘good life’, which may be associated with preventative medicine.

David Hardiman discussed an 1875 report by Dr Thomas Hendley IMS on illness, healing and ‘superstition’ among the Bhil tribal people of southern Rajasthan. He concluded that this can be read today to understand the Bhils’ attitudes towards disease and healing, despite its focus on their supposed racial characteristics and its characteristic colonial moral attitudes.

James Mills discussed the 19th- and 20th-century history of psychiatry in Mysore as a frontier between family and modern state. The foundations of modern

Western medicine were laid there during a period of Indian, rather than colonial, government, and local people quickly exploited the 500-bed psychiatric hospital established in 1920 both as a place for disturbed relatives and as a source of employment.

Sanjoy Bhattacharya identified several internal medical frontiers opened by World War II in eastern India; the war was won, after all, by meeting not merely military needs, but also civilian requirements in frontier regions that became the base for a massive Allied army. In addition to the encounter between British imperial and US military medical systems in these regions, there were famine camps where fractures in the state apparatus were apparent.



Paul Greenough discussed the frontier between European and South Asian understandings and practices in regard to smallpox, focusing on a ‘paediatric frontier’ in an effort to explain why parents would consent to vaccination rather than the better-known practice of variolation.

Monica Saavedra read out a paper prepared by Cristiana Bastos (who was unable to attend due to personal commitments), dealing with variolation in Portuguese Goa, where local interests and processes, rather than imperial authority, shaped health policies. There the colonial frontier was not a boundary between the coloniser’s Western medicine and colonised bodies/practices/resistances, but a ‘grey zone of multiple loyalties’ where local order was structured.

The wide variety of ideas developed around the concept of ‘the frontier’ suggested this device may contribute to developing more nuanced models of medical interaction in the colonial sphere.

Funded by the Centre and the British Academy, the conference was organised by Sanjoy Bhattacharya and Alex McKay.

Dr Alex McKay is a Wellcome Research Fellow at the Wellcome Trust Centre for the History of Medicine at University College London, UK (E dungog@hotmail.com).

Above:
British Army
post on the
Indo-Tibetan
border, c.1930.
Image courtesy of
Sanjoy Bhattacharya

Medical history in Manchester

VAL HARRINGTON

The conference was held to celebrate the opening of the new online catalogue of the medical archive collections at the John Rylands University Library of Manchester. The conference was run jointly by the Library and the Wellcome Unit for the History of Medicine, University of Manchester.

The audience reflected the variety of people for whom local medical history holds a special interest: members of the Manchester Medical Society, upon whose historical collections the archive is based; academic historians; and those with a general interest in local or medical history.

The day served to reinforce a number of themes that run through the University's MSc course, in particular: the relationship between medicine, science and technology; how the pattern of innovation has been shaped by relationships both within and between the medical institutions and wider civic bodies in Manchester, and between Manchester and the rest of the country; and the undoubted contribution of individual local figures to the general history of medicine, set in the context of much broader social, professional and institutional relations.

Manchester was academically prestigious, but far enough from London to adopt unorthodox organisational practices.

John Pickstone's broad overview of the last 250 years linked medical developments to broader social and cultural movements in the city. For example, in the late 18th and early 19th centuries the growing interest in the natural sciences, which went hand in hand with industrial developments in the city, provided the intellectual context and, equally importantly, the necessary finances to foster the development of both medical institutions and medicine as a profession. At the other extreme, while industrial urbanisation increasingly took its toll on the city's economic and social environment, medicine's relationship to the 'social body' became cemented as issues of sanitary and social reform took their place alongside the new anatomy schools and other elitist institutions.

This social history was the focus of Alan Kidd's paper on the cholera epidemic of 1832. Drawing on minutes from the Manchester Board of Health, and papers from Sir James Kay Shuttleworth, then Secretary to the Board, he described how the authorities predicted the outbreak but were powerless to offer any effective response.

They did, however, collect a wealth of epidemiological data, including detailed maps of affected districts and households. Although not recognised at the time, these demonstrate the pattern of water sources in the city – the number and variety of which explain why the epidemic was not, in the end, as extensive or devastating as had been predicted.

The serendipitous nature of such historical records was highlighted by James Peters and Elizabeth Gow, the archivists responsible for compiling the online catalogue. They described how a few key figures in the Manchester Medical Society were responsible for creating and preserving what has come to be such a valuable collection.

Stella Butler's analysis of the relationship between academic medicine in 1930s Manchester and the development of surgical specialisms drew on both institutional records and personal papers from the archive. Location played a key role here: Manchester was academically prestigious, but far enough from London to adopt unorthodox organisational practices. Thus, in a period in which general surgery was the norm, Harry Platt was able to use his position within local medical networks to negotiate a more specialised sphere of practice for himself.

Isolation from the centre was also a theme in Julie Anderson's talk on the history of hip replacements from 1962 to 1982. John Charnley's move from Manchester to the far-flung reaches of Wrightington Hospital, outside Wigan, gave him the necessary freedom and autonomy to concentrate on the technologies of hip replacement. Echoing Joseph Lister a century earlier, he sought to maintain control over these technologies, but ultimately, in a world dominated by the biomedical industry, his designs were copied and modified and he lost his influence over both the direction of innovation and the application of his technologies.

Technology and modernity were key to Helen Valier's history of Manchester Royal Infirmary, 1945–2002. She explored the changing functions of the modern hospital in the context of NHS reform, highlighting how both buildings and actors have had to adapt. Despite the temptation to view it as a history of Manchester doctors, Manchester medicine over the past 250 years is the product of a variety of actors and influences – and the medical archives need to be viewed within this much broader social and political context.

Val Harrington is a Wellcome Trust-funded doctoral student in the Wellcome Unit for the History of Medicine at the University of Manchester, working on a history of mental health services in Manchester and Salford since 1945.

Health, work and masculinity, c.1800–1950

BROOKE WHITELAW

The Centre for the History of Medicine at the University of Warwick hosted a workshop in December 2004, on the relationship between gender and occupational health.

This event provided a platform for discussing ways in which the concept of masculinity can contribute to historical understanding of the complex relationship between gender and occupational health across the increasingly industrialised 19th and 20th centuries and within a variety of national contexts. The workshop was held at the Modern Records Centre on the Warwick campus, the repository of a number of archives pertaining to trade unions, employers' and trade associations, and industrial relations organisations. Fourteen papers were presented at the workshop, which was organised by Hilary Marland, Vicky Long and Mathew Thomson (Centre for the History of Medicine, University of Warwick), and Martin Dinges (Institute for the History of Medicine, Robert Bosch Foundation, Stuttgart).

The question of how to deal with masculinity as a means of uncovering experiences and explaining the behaviour of male workers in the past emerged as one of the central themes. Lively debate surrounded some of the methodological problems and possibilities in placing masculinity as a conceptual tool at the centre rather than the periphery of analytic focus when dealing with perceptions, representations and experiences of illness, health and body in the workplace.

The familiar problem of source recurred with regard to consideration of how to use masculinity as an ontological basis for historical and sociological analysis of male health behaviour (Michael Meuser), and also how to relate gender identity or, more specifically, "the practice of being men" to the wider social/cultural expectations and mores inherent within, adopted by or imposed upon particular workplace cultures.

In negotiating this division between representation and social reality, a number of papers explored personal narratives of body, disease and sickness, discussing soldiers' letters home to their families during the Franco-Prussian war of 1870–71 (Manuel Richter), letters between two male workers and their wives during years of separation in war-torn Germany (Nicole Schweig), and workers' attitudes to illness and health in 19th- and early 20th-century German autobiography (Jürgen Schmidt). Such approaches allowed a more intimate view of the distinctly gendered nature of health behaviours and practices, providing unmediated, individuated testimonies of men and women as they sought to explain and control the vagaries of body and mind in the pursuit and preservation of wellness.

Another common theme and discussion point was the recognition of male workers' agency in modifying and sometimes resisting medical intervention, a defiance that highlighted the interpretive significance of class and hierarchy in the many workplace cultures under consideration over the course of the workshop. The extent to which the operation of class could explain male reluctance to embrace medical advice or examination remained an open question.



Some papers looked at particular occupational health controversies, from 'shuttle-kissing' and cotton-spinners (Joseph Melling and Pamela Dale) to anthrax among British textile workers (Tim Carter), inviting discussion of 19th- and 20th-century medical surveillance of men and women and the problem of which individuals or groups in society were privileged with a voice in these health debates. Could 20th-century industrial welfarism be viewed as the infiltration of the middle class into working-class spaces, an effort at the reformation or "cultural re-fabrication" of the young male worker (Melling in reference to Long's paper)? And to what extent did such reformist agendas reflect actual employer and medical provision?

In charting the entry of psychological specialisms into 20th-century understandings of occupational health, such as psychological conceptions of risk behaviour and male "accident-proneness" in Switzerland and Germany (Martin Lengweiler), or the problem of the "industrial misfit" in British inter-war industrial psychological literature (Brooke Whitelaw), the assertion of expertise both within and beyond the factory gates became a pertinent discussion point, as did the question of what motivated different specialist groups in their scrutiny of the industrial worker. Whether tracing the contours of political regulatory involvement in the workplace, organisational and social response to medical initiatives, or legal and trade union compensation battles, the industrial male body became a focus of professional interest and the locus upon which a

Above:
Male factory
worker with
uncluttered arms.
Colour lithograph
after Leonard
Cusden.

variety of occupational health and safety debates centred (Melling, Dale and Mark Bufton).

The propensity of middle-class (professional or lay) observers to comment on and criticise working-class lifestyles and behaviour, along with the historical specificity of gendered notions about privacy, hygiene, shame, embarrassment, cleanliness and self-control, allowed for analysis of working-class interaction with medical authority, a relationship that often blurred the boundary between what could be regarded as public and as private in examining ideas and practices of health (Dale and Melling).

Though most papers concentrated on industrial workers within British and European national contexts, several found the soldier-as-worker a fruitful source for analysis through the personal testimonies already outlined, and also in relation to institutional provision of healthcare for Indian troops in British India (Samisksha Sehrawat). The number of papers focusing on the industrial context highlighted the need to look beyond the factory, at other sites of masculinity and health, perhaps taking into account white-collar and agricultural workers. The influences of age, religion and education were singled out as issues requiring greater elaboration: age was particularly emphasised in this respect, and touched upon in a paper that dealt with statistical evidence of mortality and morbidity among elderly workers in late Habsburg Vienna (Andreas Weigl) and in another on British boy labour and industrial welfare provision in World War I (Long).

The role of women and female socialisation in influencing male health practices, where social expectations of appropriate 'manly' behaviour affected actual conduct, was highlighted as another aspect in need of further

attention, along with the need for awareness of the ways in which men created hierarchies among themselves, differentiating and delineating by trade, skill and locality, rather than solely along class lines.

Overall, the workshop provided participants with the opportunity to explore the gender politics of disease, perceptions of health and illness, and their relationship to work in an international forum. It allowed for discussion of the kinds of story and explanation that existed about certain occupational diseases, and how they influenced and were interpreted by workers and various professional groups, inviting consideration of the workplace as a site of protection for male health – while historiography has tended to focus on its potential for harm.

Contrasting geographical points of reference worked to illumine the way in which industrial and political movements, economics, the decline of the apprenticeship system, mechanisation and the relationship between man and machine (Jonathan Reinartz), along with conceptualisations and practices of skill, translated differently not only according to historical moment but also by nationality. Themes of commonality and difference across continents were continually emphasised throughout the workshop, pointing to potentially rewarding future directions in the scholarship of occupational health, where geographically and culturally distinct practices of work and health intersect and refract. This could allow historians new ways of getting at an old problem: that of revealing how men and women in the past shaped and responded to ideas of health and wellness, and what this meant for their experience of labour.

Brooke Whitelaw, Centre for the History of Medicine, University of Warwick, UK.

Centre for Medical History, University of Exeter

CALL FOR PAPERS

'Working with Dust: Health, dust and diseases in the history of occupational health'

An international comparative conference on industrial health and the politics of disease regulation since 1700.

The Centre for Medical History at the University of Exeter is hosting an international conference to be held at the Institute of Arab and Islamic Studies on 10–12 April 2006.

The conference will include the following themes:

- testaments and oral history of dusty workplaces
- coal mining: colliery diseases and the struggle for compensation
- asbestos
- silicosis to pneumoconiosis

- tuberculosis and industrial disease
- gender and industrial disease
- state responses to respiratory illness at work
- international models of dust-induced industrial illness
- the International Labour Office and the regulation of dusty work
- changing frontiers in the burden of dust-induced diseases: developing countries
- the frontier between work and the environment in the incidence of disease.

Additional themes may be included at the request of those proposing papers.

If you would be interested in contributing to the conference, please forward an abstract of 250 words to Claire Keyte, Administrator, Centre for Medical History, School of Historical, Political and Sociological Studies, University of Exeter, Amory Building, Rennes Drive, Exeter EX4 4RJ (cfmhm@exeter.ac.uk) by 29 July 2005.

Shelf preservation: Case notes of two distinguished Edinburgh clinical professors

LOUISA COLES

In April 2004, Lothian Health Services Archive (LHSA) began work on a project to preserve the Royal Infirmary of Edinburgh case notes of two notable clinical professors from the University of Edinburgh, James Learmonth and Derrick Dunlop. The project was funded through the Wellcome Trust's Research Resources in Medical History (RRMH) programme and was completed on schedule in April 2005.

LHSA has approximately 1500 linear metres of folder-based clinical case notes, which date from the early 1900s to the 1990s. The papers of Learmonth and Dunlop (www.lhsa.lib.ed.ac.uk/projects/rrmh2/rrmhld.html) were prioritised for treatment on the basis of a National Preservation Office Preservation Assessment Survey undertaken from 1999 to 2000, which considered their condition and took into account current and likely future research use.

Despite the apparent ubiquity of hospital case notes in the 20th century, it appears that relatively few series have survived, owing to current destruction policies and the general failure to implement historical sampling procedures. Subject to data protection rules and current NHS guidelines on confidentiality, the case notes held at LHSA enable scholars to investigate how general and speciality clinical medicine and surgery evolved in Edinburgh. However, they can also be used to enrich study in history of medicine in a wide range of subject areas undertaken from a number of different historiographical perspectives. They also have a variety of genealogical uses.

The case notes of James Learmonth (1895–1967) and Derrick Dunlop (1902–1980) are likely to be of particular value to academic researchers because of the men's reputations, practices and publications. Both also had some connection with the royal family: Learmonth performed a lumbar sympathectomy in 1949 on George VI, who created him KCVO; Dunlop was knighted in 1960 for his services to medicine and made Physician to the Queen in Scotland in 1961.

Learmonth was University Professor of Surgery from 1939 to 1956 and held the Regius Professorship of Clinical Surgery from 1946. One of the last general surgeons, he continued to practice and teach throughout the war years, which adds considerable interest to surviving notes over that period. Learmonth also specialised in peripheral nerve and vascular injuries. There are no personal papers for him, but his CV, a bibliography and some off-prints have been preserved in Edinburgh University Archives.



Derrick Dunlop was Christison Professor of Therapeutics and Clinical Medicine from 1936 to 1952. He published over 100 papers and was a prolific textbook author as well as a distinguished teacher of clinical medicine. He specialised in the treatment of metabolic disorders, and many of his publications give detailed accounts of trials involving new drugs for diseases and conditions such as Addison's, thyrotoxicosis, hyperthyroidism, asthma, tuberculosis and diabetes. After retiring from his Chair, Dunlop acquired a national reputation for his work on drug safety and control. His personal papers are housed separately in LHSA and consist mainly of off-prints of his publications, reviews, lectures, addresses, medical journal and drug company-related correspondence, materials from the Safety of Medicine Committee and Wellcome Foundation symposia, and other aspects of his professional work.

Prior to the project, the case notes were kept in folders composed of poor-quality materials that exhibited extensive surface dirt and, frequently, physical and chemical degradation. Therefore they did not provide adequate protection for the contents. The case notes themselves exhibited surface dirt, tears, creasing and losses to edges. Additional damage to the paper was noted in areas coincident with rusty metal paperclips and staples. Treatment undertaken as part of the project addressed these problems: paperclips and staples were removed, creases realigned and surface cleaning carried out. Any photographic prints discovered were stored in single-crease folders of photographic storage paper and, together with the treated case notes, rehoused in single- or double-crease premier-grade archival paper

Above:
Shelves of
records before
(top) and after
preservation.

folders. The new folders have been stored vertically in custom-made drop-spine boxes.

The Learmonth and Dunlop project succeeded a 2002–03 RRMH project, in which similar work was carried out on the case notes of the Edinburgh clinical professors Edwin Bramwell and Norman Dott (www.lhsa.lib.ed.ac.uk/projects/rrmh/rrmhbd.html). These and the other case notes held in the LHSa, along

with those in other repositories across Scotland, are accessible through the Finding the Right Clinical Case Notes database (www.clinicalnotes.ac.uk).

The conservators working on the Learmonth and Dunlop project were **Kate Kidd** (E kathryn.kidd@ed.ac.uk) and **Louisa Coles** (E louisa.coles@ed.ac.uk). It was supervised by **Ruth Honeybone** (E ruth.honeybone@ec.ac.uk) and managed by **Dr Mike Barfoot** (E mike.barfoot@ed.ac.uk).

New publication

Health Policy in Britain's Model Colony: Ceylon (1900–1948) by Margaret Jones.

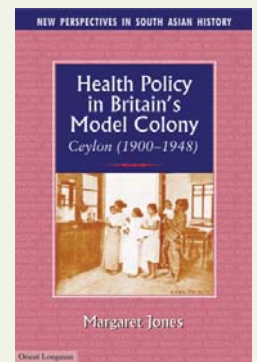
Was Western medicine a positive benefit of colonialism or one of its agents of oppression? This question has prompted a vigorous historical and political debate and is explored here in the context of the 'model' British colony of Ceylon.

In this study, Margaret Jones emphasises the need for both a broad perspective and a more complex analysis. Colonial medicine is critiqued not merely in the political and economic context of imperialism, but also against the background of human needs and rights. Her research is underscored by a detailed analysis of public health measures and services in Ceylon. One of its key findings is the accommodation achieved between Western and indigenous medicine. Throughout this work, Jones provides nuanced readings of the categories of colonised and coloniser, as well as the concept of colonial medicine.

Health Policy in Britain's Model Colony provides an understanding of historical trends while simultaneously avoiding generalisations that subsume events and actions. Written in a compelling and lucid style, it is a path-breaking contribution to the history of medicine.

Jones M. *Health Policy in Britain's Model Colony: Ceylon (1900–1948)*. Hyderabad: Orient Longman; 2004. ISBN 8 12502 759 9 www.orientlongman.com

Contact Ms Veenu Luthria for further information (E veenul@yahoo.com).



Research Assistant opportunity

The Wellcome Trust Centre for the History of Medicine at University College London wishes to employ a Research Assistant, with postgraduate qualifications and some relevant research experience, to work with Dr Sanjoy Bhattacharya for six months on a Wellcome Trust-funded pilot project entitled 'Refugee health in the UK, c.1945–1980'.

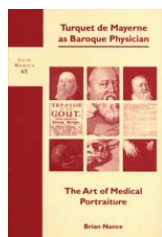
As the project will be focusing particularly on the experience of South Asian refugees, it is hoped that the applicant will be able to offer a working knowledge of Bengali or Tamil. In addition, the candidate will be expected to have one or more of the following skills:

the capability to deal with a range of historical sources; an awareness of the workings of British and United Nations archives; and the aptitude for conducting and transcribing interviews.

Last date for the submission of completed applications is 25 August 2005, and interviews will be held in late September 2005 (the candidate will be expected to join the Centre on or around 1 November 2005). The salary is approximately £21 000 per annum (pro rata).

Informal enquiries about this opening can be directed to Dr Sanjoy Bhattacharya (sanjoy.bhattacharya@ucl.ac.uk).

Turquet de Mayerne as Baroque Physician: The art of medical portraiture



CANDICE DELISLE

Theodore Turquet de Mayerne (1573–1665) was a court physician to Kings Henry IV of France and James I of England. He was also widely famous for his abilities as a practitioner and his meticulous case records.

These records of his consultations provide Brian Nance with a means of examining the medical consultation during the early modern period. A consultation was a crucial moment for both physician and patient: the moment where the theory learned at university had to enter into action. Here, the physician was confronted by the particulars of the case and the constraints of practice.

After a brief biographical account of Mayerne's life and education, highlighting his courtly medical practice and his beliefs in chemical medicine, Nance presents his main source: Mayerne's casebooks. The physician recorded his consultations, and later prepared these records for publication, under the title *Ephemerides Morborum*. Mayerne intended the casebooks as help for his deliberation, using them to think about the case at hand or to keep a memory of his decisions in similar cases. He also devised them in order to illustrate the worth of his chemical theories and of his abilities as a court physician.

The standard order of the records followed the chronology of a consultation: the first section was an account of the patient's details and symptoms; a second was devoted to the diagnosis and the prognosis; the goals of the treatment were then stated; and finally remedies were prescribed. Nance establishes how Mayerne used this encounter to draw a cumulative, complex and 'baroque' portrait of his patient, by evaluating history and temperament. Mayerne did not perceive the patient's temperament as a permanent state, but as a transient and fluctuating quality. Therefore, the portrait he drew had to take into account the history of the case, and to rely for that on the word of the patient. The physician then moved towards a more theoretical approach in order to establish a diagnosis, while complex and competing notions of diseases, symptoms and signs came into play.

Here, Nance understands the moment of the diagnosis as a struggle between medical theories about disease and the presentation of an individual and a practical case. He also attempts to place Mayerne's diagnoses against the framework of the social context. Mayerne's clientele appeared to have been mostly composed of gentlemen, and the selection he made when preparing the publication accentuated that character. Therefore, in contrast with the more common diagnoses made in

the Bills of Mortality, Mayerne mostly diagnosed courtly diseases (such as gout). In a short and moving chapter, Nance then attempts to get an idea of the bedside attitude of Mayerne confronting a condemned patient, before he turns to the therapeutics and highlights Mayerne's complex understanding of disease as caused both by humoral and chemical causes. Finally, a case study of the mysterious death of Prince Henry illustrates another, clearly apologetic, aim of the casebooks: defending their author in controversial and potentially dangerous cases.

This book interestingly treats one of the new medical genres of the early modern period: a genre originating in everyday medical practice, and in the 16th-century *Observationes*. Looking at manuscripts allows Nance to get valuable insights into the medical and consultative practices of the time, thus casting light on the relationship between patient and court physician. He also shows the historical worth of a closer look at the text, and especially to the words used by the practitioner. Nance moreover provides interesting, if somewhat textbookish, accounts of the period's medical genres and theories. For instance, he focuses on the teaching of medicine in Montpellier and on the understanding of disease in the early modern period.

Another noteworthy point the book makes is the complex way in which Mayerne (and certainly his fellow practitioners) considered patients and diseases. The conditions were rarely simple, and determining a patient's temperament could not be done in any easy and direct way. The profession supposed to use both traditionally Galenic views and more recent ideas on the chemical causes of disease. Nance provides a nuanced and subtle view of the framework in which 17th-century physicians worked and established their diagnoses and therapeutics, and draws a baroque portrait of Mayerne himself.

Whereas the author's attempt to place the cases in the epidemiological background of the time might be judged a trifle too descriptive, the book deserves a reading for bringing us to the bedside: a place with no space for single-mindedness, but where the good physician had to be able to draw a complex portrait of his patient, to deal with his colleagues and his colleagues' theories, and, in his courtly background, with the political implications of health and illness.

Nance B. Turquet de Mayerne as Baroque Physician: The art of medical portraiture. Clio Medica 65. Amsterdam, New York: Editions Rodopi; 2001.

Candice Delisle is a doctoral student at the Wellcome Trust Centre for the History of Medicine at University College London (E ucgacde@ucl.ac.uk).

Enduring Memories: A paediatric gastroenterologist remembers

RICHARD BARNETT

In recent years, medical historians have spilt much ink over the subjects of specialisation in modern hospital medicine and the role of practitioners in writing medical history. These controversies seem as far from resolution as ever, and the battle lines remain drawn.

Some readers may not, therefore, feel they have reason to celebrate the appearance of this book, written as it is by a retired consultant physician and dealing principally with the development of his speciality. Perhaps in response to the mixed feelings his autobiography is likely to engender among historians, Professor John Walker-Smith opens on a note of self-deprecation: "The professional historian of medicine may find little interest in this autobiography of one academic doctor, a minor player in the medical world, struggling to develop one small speciality. There are no great names or great discoveries here."

A slice of personal reminiscence with an interesting perspective on the process of specialisation

Not so. There is much here that will engage anyone, professional or amateur, with an interest in the history of Western hospital medicine in the 20th century. The author interweaves three narrative threads – his personal history, his professional life in London and Sydney, and the establishment of paediatric gastroenterology as a speciality – with illuminating asides on such diverse subjects as the poetry of Alfred Housman, the influence of PowerPoint on the hospital case conference and international differences in white-coat etiquette. His enthusiasm for and knowledge of his subject shines through lively (though sometimes poorly edited) prose.

Walker-Smith devotes the first 12 chapters to a broadly chronological outline of his life and career. An account of an idyllic Australian childhood tinged with the shadow of Japanese imperialism sits well with those of his contemporaries (perhaps most closely with Clive James's *Unreliable Memoirs*) and serves to remind us that the threat of invasion was as real for the inhabitants of wartime Sydney as it was for blacked-out and butterless Londoners. His memories of the University of Sydney Medical School are leavened by references to the diary he kept in this period. Descriptions of terrifyingly deadpan ward sisters, demonstrations of 'pink disease' and the opportunity to take a human brain home at weekends for private dissection practice provide insight

into 1950s medical education, serving to dispel any fantasies we might have had regarding a 'golden age' of undergraduate medicine. Walker-Smith is not afraid to pass judgement on those whom he encountered; prudently, he has moderated this tendency in discussions of more recent times.

Probably of most interest to historically minded readers is the author's account of his postgraduate training. He describes his work in many situations: as an overworked, underpaid junior in the Royal Prince Alfred Hospital in Sydney (named after Queen Victoria's second son, shot in the buttock during a state visit); working his five-week passage to England as a merchant ship's surgeon; training in the Hammersmith Royal Postgraduate Medical Centre (RPMC), Zurich and Sydney; and finally as a consultant and professor of paediatric gastroenterology in London. It is interesting to find the RPMC cited once again as a major influence on British medical specialisation, and also to note the role of Walker-Smith's colleague and former boss Sir Christopher Booth in his choice of career.

The remainder of the book is taken up with the author's reflections on the history of specialisation in general, the relationship between Australia and the UK (and the role of the royal family in maintaining this) and the place of religious belief in medical practice. Some of these chapters – on the Tomlinson report, the current state of paediatric gastroenterology, the controversy over MMR and autism – may be of more current interest to the physician or journalist than the historian, although this will change with time. It must be said that this volume's usefulness to future readers would be augmented by the presence of a bibliography of the author's clinical publications, and also short biographies for some of the key names encountered in the text.

This book is a slice of personal reminiscence with an interesting perspective on the process of specialisation, and will surely take its place in many libraries of medical biography.

Walker-Smith J. *Enduring Memories: A paediatric gastroenterologist remembers*. County Durham: The Memoir Club; 2003.

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For Fear of Pain: British surgery, 1790–1850



STEPHEN CASPER

Commercial history of medicine often advertises itself through nauseating descriptions of 18th- and 19th-century hospital operating rooms. Such aggrandisement of suffering seems to invoke blood more for the effect than for historical accuracy. Fortunately for us, Peter Stanley's *For Fear of Pain* resists such temptations.

Through a series of startling (but never grotesque) narratives, Stanley asks his reader to consider the social history of the operating room before the advent of painless surgery. He asks how surgeons could cut conscious patients, and how conscious patients could bear being cut. To answer these questions, Stanley blends the institutional, educational and military contexts of British surgery with pre-anaesthetic digressions from the voices of patients, surgeons and other witnesses to painful surgery.

Stanley first explores the differences within the medical profession. While physicians continued to see themselves as superior to the 'operators' in this era, increasing patronage and medical successes enhanced the surgeons' public prestige. Those in coveted positions in universities captured the public's imagination, which stimulated jealousy among less fortunate colleagues. The rivalry this created within the profession meant ambitious competitors would magnify operative failures.

Stanley argues that the world of surgery between 1790 and 1850 was marked by changes in scientific knowledge. Surgeons adjusted techniques and therapies throughout this period, and the prevailing treatment ethos proposed intensifying pain in unaffected areas of the body to alleviate chronic or acute complaints. The 'cure' was as painful as the infection, and sepsis was sometimes the product. As physiological and anatomical knowledge disseminated into the surgical communities, it became apparent that while surgeons understood the pathology underlying patients' ailments, their treatments rarely succeeded. This stimulated the emergence of a non-interventionist ethos.

Nonetheless, 'capital operations' were sometimes necessary, and these entailed surgeries such as amputation. The procedures were dangerous and painful (although less so than might be expected). Sometimes surgery was less for the patient's benefit and more to serve the ambitions of young men hoping to make names for themselves. Reputations were also established following battles, and soldiers and sailors came to view surgeons as overly enthusiastic. Yet this "hard set of butchers" was not as eager to operate as contemporary views suggested. Stanley argues that by the mid-19th century the wounded were often more inclined to ask for amputations than the surgeons were to provide them.

Conditions on battlefields were dramatic, but hospitals in this period were not necessarily the places of horror stereotypes today suggest. Whether in London or Edinburgh, hospitals were connected to the adjacent communities. Though they were becoming places promoting healing and easing death, hospitals were also difficult places to access and often the sick would be turned away. The operating rooms were loud and raucous, and the chances of death from post-operative infection were appalling. As the hospitals were reorganised and post-operative care changed, mortality rates following surgery fell. Increasingly, medical students also appeared in various hospitals. They would formerly have been trained as apprentices, but in the new medical schools, education consisted of courses and ward rounds. This system encouraged larger numbers to enter the profession. But experiences in surgery were few and far between: often students would learn theory only and never perform an operation.

The decision to perform surgery was not autocratic, especially in the early days of the surgeons. Sometimes the decision to operate was made by several surgeons. Friends, family members and the surgeons often made decisions together, and family consent was frequently requisite. The fear of surgery was often enough to cause shock, and surgeons sought to instil confidence in their patients as they both mentally prepared for 'the cutting part'. During surgery, operating rooms became entirely different spaces. The rooms changed the moment that saw and leg, for instance, interacted.

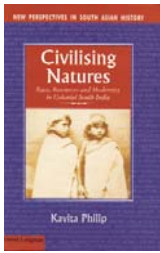
Stanley explores the environment of the operating room when children were involved. Children presented special problems and diseases, and yet they seem to have handled painful surgery as well as adults. The final chapter of the book explores ways in which pain was alleviated first by mesmerism and then by ether or chloroform. That painful surgery should have continued following the advent of painless surgery is interesting given the history Stanley has so masterfully told here.

For Fear of Pain is an excellent and useful book. While on some occasions Stanley seems too willing to accept accounts from the period (for example, the tale of Hoo Loo), this book nonetheless stimulates many interesting questions. *For Fear of Pain* is a moving and provocative account of a world difficult to imagine and painful to contemplate, and would be a great place to begin research into the social history of pain.

Stanley P. *For Fear of Pain: British surgery, 1790–1850*. Clio Medica 70. Rodopi: Amsterdam and New York; 2003.

Stephen Casper is a doctoral student at the Wellcome Trust Centre for the History of Medicine at UCL (E ucgastc@ucl.ac.uk).

Civilising Natures: Race, resources and modernity in colonial South India



KAVITA SIVARAMAKRISHNAN

Kavita Philip's *Civilising Natures* examines the construction of colonial scientific modernity and its civilising practices in the 19th and early 20th centuries, which were shaped simultaneously by the British colonial State's priorities and the influences of the global political economy.

It reconstructs the discourses of science and its practices through the rhetoric and debates generated by disciplines such as scientific forestry, natural history and ethnography.

The choice of these disciplines even the author admits is somewhat eclectic, and the agents whose ideas, writings and activities shaped these scientific discourses are equally diverse. In various chapters of this book, covering plantation owners, missionaries and ethnographers, the construction and deployment of notions of scientificity are revealed, culled from a regional south Indian archive of official records, reports and contemporary writings.

Philip, however, is successful in probing the interacting, overlapping constructions of anthropologists, missionaries and plantation owners as they sustained and legitimated these scientific discourses. Indeed, the central strength of this work lies in the fact that despite somewhat brief surveys of all of these themes, including engagements with recent writings, Philip rescues the work from simply lapsing into a set of historiographical surveys punctuated by her comments on these disciplines.

Her narrative links an account of the evolution of the Nilgiri hill stations, a socioeconomic history of forestry and plantations, and the history of disciplinary anthropology to Christian missionary activity, all of which are also situated in the wider context of the new modes of thought and production that were being established through the 19th century. This is particularly well illustrated in her chapters on 'forests and plantations'. In the context of the Nilgiri tribes, *Civilising Natures* reconstructs the intersection of tribal patterns with missionary as well as Forest Department rhetoric and interventions that eventually brought tribes into relationships of production and interdependence that were oriented to colonial state interests.

The main argument in *Civilising Natures* centres on the configurations of scientific modernity itself. It contends that there were important relationships and continuities between pre-existing forms of local use and the constructions of a scientific, civilisational progress. In 'scientific' forestry even in the early 19th century, forest officials investigated prior forms of land use. In the case of the Kurumbas, the Forest Department documented the organisation and segmentation of tribal

groups, just as forest officials recorded the social dynamics of Nilgiri tribes such as the Sholagas and Badagas.

The interweaving of the domains of science, culture and ideology, Philip argues, formed a mutually constitutive, 'mixed' colonial modernity. This is arguably best illustrated in her account of missionaries and their projection of civilisational progress in terms of the imperatives of managing nature and scientific progress. Christian missionaries interlinked older discourses of civilisational progress from savagery to modernity with the binaries of superstition/science. Missionary work therefore typified the coexistence of scientific, secular and economic modernity.

However, a caveat regarding Philip's analysis of the scientific-moral discourse characterising missionary activity may be added. While 'scientific' categories and legitimisation did fundamentally alter the ways in which Christian missions conceived of their civilisational tasks, these ideas and practices were also the source of persistent dilemmas for Christian medical missions in the late 19th and early 20th centuries. Philip does explore the responses to scientific, modernising discourses in the context of forestry, plantations and ethnographic studies, but her account does not include a discussion of impacts in the context of Christian missionary ideas and work.

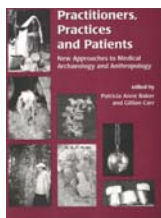
Medical Missionaries, whom Philip cites as deploying a 'scientific' discourse and practices, were conscious of the limited inroads and impact of 'scientific' rhetoric and healing in proselytisation. American Presbyterian denominations, for example, who were engaged in medical work in North India, often voiced these concerns in their letters to their boards, medical missionary conferences and in their reports.

The place of this missionary scientific-moral discourse and its relationship with the colonial State was complex and its relationship with colonial 'scientific' medical interventions was ambivalent as the colonial administration began to demarcate secular, scientific norms and spaces in professional medical practice and medical colleges. Medical missionaries and their ideas therefore need to be understood as both being part of the colonial discourses and legitimating the State's priorities, as much as engaging with defining their own place and labours.

Philip K. *Civilising Natures: Race, resources and modernity in colonial South India*. New Perspectives in South Asian History 6. India: Orient Longman; 2003.

Dr Kavita Sivaramakrishnan is an independent researcher (E kavitasiva03@yahoo.co.in).

Practitioners, Practices and Patients: New approaches to medical archaeology and anthropology



RETHY K CHHEM

The main goal of this collection is to introduce the reader to medical archaeology and anthropology as a field for the cultural construction of the human body and diseases.

The book contains 15 chapters written by experts from a wide range of backgrounds. Despite their great diversity, these research projects share a number of common goals including understanding the medical dimension of archaeological and anthropological research. Overall, the book covers the construction of anatomical knowledge, evaluation of the reaction of human bodies to sickness, diagnostic and therapeutic methods using different types of divination, and tools of healing.

I have learned a great deal from the wide variety of research methodologies discussed in this handbook

In addition to this interdisciplinary approach to medical anthropology and archeology, the case studies presented are drawn from myriad geographical regions and historical periods. The geographical range includes China, England, Nepal, Greece and the western Amazonian region; the eras span the late Iron Age, early Roman Britain and the late warring states of China. Despite this diversity, most authors have concentrated on two main dimensions of human history: the human being treated first as a biological organism and second as a social person. Traditionally, these aspects have been interpreted separately by archaeologists and anthropologists, but given the book's main theme, the contributors have tried to use a unique interdisciplinary interpretation of facts by considering "the cultural complexity of medical ideologies, beliefs, and practices".

Above all, the concept of human anatomy in the cultural context is a major strand throughout this volume. For instance, the role of mercury and jade in the preservation of the body before and after death is discussed in great detail, supported by archaeological records in ancient China.

Diseases, as biological reactions of the human body to the environment, are a second major theme (including discussion of semantic differences between illness and disease). Medical archaeologists have used human bones as biological materials to study ancient diseases from the point of view of palaeopathology, and also to

demonstrate the role of ancient skeletons as material culture. A thorough discussion of tuberculosis illustrates the importance of the interdisciplinary approach, emphasising the limitations of the exclusive use of palaeopathological data as an approach to uncover disease of the past. For example, the presence of disease stigmata in ancient bone represents only the tip of the iceberg, as many diseases might have affected or killed ancient populations without the appearance of bone lesions. Thus case reports on ancient bone diseases may not be representative of the real epidemiology of ancient disease.

Because of my interest in the history of ancient medicine and disease, I have learned a great deal from the wide variety of research methodologies discussed in this handbook, including the use of anthropological data to address historical questions not answered by literary sources or archaeological records.

The overall layout and format of the book is quite practical, although, given the book's interdisciplinary paradigm, there is a difficulty in organising the sections and chapters. The illustrations, including photographs and diagrams, are of high quality. It would have been interesting to have the names of contributors listed with their respective areas of expertise and academic affiliations, as it would allow the reader to have a full grasp of the theories and methodologies covered.

This book may be of interest to historians, especially historians of medicine and diseases, archaeologists working on burial sites, bioanthropologists and cultural anthropologists, and also scientists trying to understand modern diseases and evolution in time. I would strongly recommend it to scholars and graduate students working in the overlapping fields of medical history, archaeology and anthropology.

Baker PA, Carr G (eds). *Practitioners, Practices and Patients: New approaches to medical archaeology and anthropology*. Oxford: Oxbow Books; 2002.

Rethy K Chhem is Professor of Radiology and Anthropology and Chief of the Department of Radiology, University of Western Ontario, Canada (E bengmealea@yahoo.com).

Visitors to the Wellcome Trust Centre

Visitors to the Wellcome Trust Centre for the History of Medicine at UCL from March to July 2005 include:

Luciana Caliman* (Max Planck Institute),
The historical constitution of the inattentive individual in the 19th century.

Dr Chen Ming* (Peking University), The Indian influence on Chinese medicine in medieval China: A study on medical manuscripts from Dunhuang and Central Asia (via the K C Wong Fellowship of the British Academy).

Dr Diana Daich de Eidelstztein (University of Buenos Aires), The history of the dental profession.

Miriam Focaccia* (University of Bologna),
The development of anatomical science between the 17th and 18th centuries.

Dr Li Shang-Jen (Academia Sinica, Taiwan),
Healing bodies, saving souls: Medical missions to 19th-century China.

Prof. Mary Lindemann* (University of Miami),
The medical and biological determinants of civil competency in 17th- and 18th-century northern Europe.

Dr Javier Moscoso* (University of Murcia),
The history of pain.

Prof. Warren Winkelstein (Professor Emeritus, University of California, Berkeley), Vignettes of the history of epidemiology.

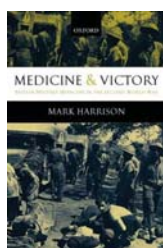
Prof. Lisa Wynne Smith* (University of Saskatchewan), 'By this resolve shall helth and mony save': Men's health and household management in England and France (c.1670–1789).

Dr Zhen Cheng* (Peking University),
The introduction of Western nursing to China in the 19th and 20th centuries.

* at the Wellcome Trust Centre at the time of publication.

Sally Bragg, Affiliation and Programmes Administrator (E s.bragg@ucl.ac.uk). Apologies to those visitors whose plans were not finalised at the time of writing.

Award for historian



Dr Mark Harrison, Director of the Wellcome Unit for the History of Medicine, Oxford, and a Fellow of Green College, has been awarded the 2004 Templer Medal for his book *Medicine and Victory: British Military Medicine in World War Two*.

The Templer Medal book prize, awarded by the Society for Army Historical Research, was established in 1982 to commemorate the life and achievements of Field Marshal Sir Gerald Templer KG, and to mark his presidency of the Society between 1965 and 1979. The Medal is awarded each year to the book that makes the most significant contribution to advancing knowledge and understanding of the history of the British Army.

Medicine and Victory is the first comprehensive account of British military medicine in World War II since the publication of the official history in the early 1950s. Drawing on a wide range of official and non-official sources, the book examines medical work in all the main theatres of the war, from the front line to the base hospital. All aspects of medical work are covered,

including the prevention of disease, and the disposal and treatment of casualties.

In the book, Dr Harrison (below) argues that the medical services played a major role in the Allied victory, enabling the British Army to keep a higher proportion of troops in the field than its opponents. Assuming no previous knowledge of either medical or military history, *Medicine and Victory* provides an accessible introduction to an often-neglected aspect of World War II.



Calendar of events

TO ADD AN EVENT TO THE CALENDAR PAGE, PLEASE SEND DETAILS TO THE EDITOR, sanjoy.bhattacharya@ucl.ac.uk

SEPTEMBER 2005

- 1–4 21st Congress of the British Society for the History of Medicine**
Institute of Arab and Islamic Studies, University of Exeter
Contact: Claire Keyte (E cfmh@exeter.ac.uk)
- 7–10 Cultural History of Health and Beyond**
Joint conference of the Society for the Social History of Medicine and the European Association for the History of Medicine and Health
Ministère de la Recherche, Paris, France
Contact: Patrice Bordelais (E bordela@ehss.fr)
- 15–16 Hybrids and Partnerships: Comparing the histories of indigenous medicine in southern Africa and south Asia**
Osler McGovern Centre, Oxford
Contact: wuhmo@wuhmo.ox.ac.uk
- 15–18 Sixth International Symposium on the History of Anaesthesia**
Queens' College, Cambridge
Contact: Dr Neil Adams (E adams118@keme.co.uk)

NOVEMBER 2005

- 2–4 Global Health Histories**
National Library of Medicine, Bethesda, USA
Contact: Paul Theerman (E paul_theerman@nlm.nih.gov)
- 24–25 Apothecaries, Art and Architecture: Interpreting Georgian medicine**
Apothecaries Hall, London
Contact: archivist@apothecaries.org

DECEMBER 2005

- 5 One-day conference in the history of altitude medicine**
Centre for the History of Science, Technology and Medicine, University of Manchester
Contact: Jorge Lossio (E jorge.lossio@stud.man.ac.uk)

JANUARY 2006

- 9–10 History of Medicine in South-east Asia**
Center for Khmer Studies, Siem Reap, Cambodia
Contact: Lesley Perlman (E lperlman@khmerstudies.org)
www.khmerstudies.org/events/medecine.htm

MARCH 2006

- 22–25 European Social Science History Conference**
Amsterdam, The Netherlands
Contact: Els Hiemstra (E ehi@iisg.nl) www.iisg.nl/esshc

APRIL 2006

- 10–12 Working with Dust: Health, dust and diseases in the history of occupational health**
Centre for Medical History, University of Exeter
Contact: Claire Keyte (E cfmhmail@exeter.ac.uk)

MAY 2006

- 11–13 International Conference on the History of Suicide**
McMaster University, Hamilton, Canada
Contact: Dr David Wright (E dwright@mcmaster.ca)

For a fuller listing of lectures, seminars, conferences and other events relating to the history of medicine, visit <http://medhist.ac.uk/events>.

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Contributor guidelines are available at www.wellcome.ac.uk/wellcomehistory

Contributions should preferably be pasted into an email and sent to the Editor (E sanjoy.bhattacharya@ucl.ac.uk).

Dr Sanjoy Bhattacharya

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